DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

ROBERT G. MCSWAIN

ACTING DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

HOUSE NATURAL RESOURCES COMMITTEE

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING

ON

H.R. 5608

April 9, 2008

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good Morning. I am Robert McSwain, Acting Director of the Indian Health Service. I am pleased to have the opportunity to testify on H.R. 5608.

IHS strongly opposes this bill because it adds unnecessary administration burdens that would divert resources from the provision of health care services.

With respect to the scope of the consultation requirements in the bill, the section 2(4) definition of "policies that have tribal implications" is all-encompassing, thus seemingly removing any agency discretion from the IHS Director and arguably making all agency decisions subject to tribal consultation. Under section 4(3) of the bill, IHS would be required to encourage Tribes to develop their own policies to carry out IHS programs and IHS would be required to defer to such policies if they do not violate other laws. Both of these requirements appear to encroach on the authority of the Executive Branch. In addition, section 2(1)(D) of the bill requires, without any exception, that as part of the proposed accountable consultation process, "any policies that have tribal implications" shall not become effective until at least 60 days after written notification to tribal officials. This provision imposes a requirement that fails to consider circumstances, including emergencies, in which waiting 60 days is not practicable.

Language in Section 6 of the proposed bill is of great concern given our costs to implement much needed improvements to our financial systems and the ongoing priority to improve and assure the security of our IT systems in the implementation of electronic health records and other health management systems beneficial to both the IHS and tribally administered health programs. The IHS will not have the funds available to make these improvements without negatively impacting services provided to the Tribes.

In the last section of the bill, addressing the process for Indian tribes to apply for waivers of statutory and regulatory requirements, the language states a decision should be rendered "not later than 120 days of receipt of such application by the agency, or as other wise provided by Federal law or regulation." This proposed change would actually increase the current statutory time limit of 90 days and slow down the federal response to a tribal request for a waiver.

The IHS Consultation policy provides for consideration of Tribal interests in Federal decision making policy while assuring that its Federally Inherent responsibility is carried out. It also serves all Tribes regardless of how Tribes choose to have the IHS funded health services administered to its tribal members - by tribal contract or compact under the Indian Self-Determination and Education Assistance Act for all or portions of their health program, or directly by IHS through the federally operated system.

The IHS provides health services to nearly 1.9 million American Indians and Alaska Natives. In carrying out its responsibility, the IHS maintains a unique relationship with more than 560 sovereign Tribal governments that represent a service population in some of the most remote and harsh environments within the United States as well as in modern metropolitan locations such as Anchorage and Phoenix. For all of the American Indians and Alaska Natives served by these programs, the IHS is committed to its mission to raise their physical, mental, social, and spiritual health to the highest level possible in partnership with Tribes.

The IHS consultation policy was originally developed in 1997 in response to a 1994 Presidential Memorandum to Heads of Executive Departments and Agencies, and has been revised in response to the subsequent Executive Orders on Consultation and Coordination with Indian Tribal Governments, and tribal government requests for improvement. The development and revisions of the IHS policy is an example of Tribal Consultation in action as it has been the product of a workgroup comprised of Tribal

Leaders in collaboration with IHS federal representatives. The IHS policy on Tribal Consultation was last revised and published in January 2006. This revision too was accomplished through a workgroup of Tribal Leaders and IHS representatives working together to enhance Tribal consultation in virtually every facet of our interactions with Indian Tribes. The IHS remains committed to carrying out tribal consultation consistent with the current Executive Order, Presidential Memorandum, and the Department of Health and Human Services (HHS) Tribal Consultation policy. We encourage and facilitate increased Tribal participation and collaboration at all levels within the IHS system.

The IHS Tribal Consultation Policy describes our commitment to working in partnership on a Government-to-Government basis with Indian Tribes. It is designed to enhance collaboration and partnership between IHS local operating units, Area Offices, and Headquarters and Indian Tribes to ensure that the requirement for Tribal consultation permeates the entire IHS system.

The IHS will consult with Indian Tribes to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes. This includes policies with Tribal implications and that have substantial direct effects on one or more Indian Tribes served by the IHS as a result of their special government-to-government relationship.

For example, as partners with the IHS in delivering needed health care to American Indians and Alaska Natives, Tribal leaders and health program representatives participate each year in an extensive consultation process as part of IHS' budget formulation activities. This process begins with IHS staff, Tribal leaders and health program staff, and Urban Indian health program representatives at each IHS Area developing recommendations for budget changes linked to health priorities. Then, at a national meeting of Tribal representatives, a national set of health priorities and budget

recommendations are developed based on input from each of the 12 Areas, and which are presented by tribal leadership to the Department at its annual Tribal budget consultation session. The tribal recommendations guide that fiscal year's budget priority setting decisions within the IHS and HHS. On other non-budget matters, Tribal consultation also occurs when appropriate.

Currently, the IHS has 8 advisory committees and workgroups comprised of Tribal Leaders and/or their representatives established to provide input from the Tribal leadership and Tribal community to the agency. These advisory committees or workgroups are: Tribal Leaders Diabetes Advisory Committee, Health Promotion and Disease Prevention Advisory Committee, Direct Service Tribes Advisory Committee, Tribal Self Governance Advisory Committee, IHS Budget Formulation Workgroup, Contract Support Cost Workgroup, Facilities Appropriations Advisory Board. Additionally, a Behavioral Health Advisory Committee is in the process of being formed.

On the Departmental level, HHS also holds regional consultation sessions, in addition to the national annual Tribal budget and policy consultation session, to provide opportunities for Indian Tribes and HHS officials to discuss various budget and policy issues. There are a number of HHS advisory committees in which Tribal officials and authorized staff participate to communicate their interests and provide Tribal input: Center for Medicaid and Medicare Services Tribal Technical Advisory Group; Centers for Disease Control's Tribal Consultation Advisory Committee; and the HHS American Indian/Alaska Native Health Research Advisory Council. The IHS and HHS have already put considerable effort and resources into assuring that consultation and other communication with Tribes is accomplished to the largest degree practicable.

We believe the IHS Tribal Consultation policy and practices in place are an open, collaborative and effective communication process that have greatly enhanced the capability of the IHS and Tribally operated health programs to work in partnership to make the best possible decisions. The bill under consideration by this committee is significant and very broad in its scope and, while well intended, would place unnecessary burdens and costly undertakings on the IHS that would serve to divert resources away from needed health care services to implement these activities.

In closing, the provisions in the proposed bill clearly are intended to mandate that a high degree of consultation with Tribes should take place. The IHS routinely undertakes a high level of appropriate consultation. As such, we believe this legislation would impose an unnecessary burden and limit the discretion of the Secretary and the IHS to prioritize health care to American Indian and Alaska Native people.

Thank you for this opportunity to present on behalf of the IHS with regard to H.R. 5608. I am pleased to answer any questions that you may have.